

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | |
|--|--|---|---|---|
| 1. DECEASED-NAME (Type or Print) Capt. HILLRY B. AKERS | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year 2/12/69 | | 2b. HOUR 11:30 AM |
| 3. SEX male | 4. RACE white | 5. DATE OF BIRTH 6/10/1893 | 6. AGE (In years last birthday) 75 YRS. | IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> |
| 7a. BIRTHPLACE (State or foreign country) Rock Hall, Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Kent |
| 10. CITY OR TOWN OF DEATH Chestertown (DOA) | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Boat capitan |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Kent CITY OR TOWN Rock Hall | | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13c. STREET AND NUMBER Main St. | |
| 14. FATHER'S NAME First George Middle Akers Last Akers | | 15. MOTHER'S MAIDEN NAME First Martha Middle Sewell Last Sewell | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Merchant Marines | | 16b. SOCIAL SECURITY NO. 217 72 6891 | 17. INFORMANT ADDRESS Mrs. Kitty Akers - Rock Hall, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease 4124 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE Robert W. Farr EXAMINER'S NAME (Type) Chestertown, Md. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county) | | 22b. DATE SIGNED 2/13/69 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 2/16/69 | 23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cem. | 23d. LOCATION (City or Town) (County) (State) near Chestertown, Md. | |
| 24. FUNERAL DIRECTOR J. Wilks Wells | | ADDRESS Chestertown, Md. | | 25a. REC'D BY REGISTRAR FEB 17 1969 |
| | | | | 25b. REGISTRAR'S SIGNATURE |

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WALL & COMPANY

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FOR STATE HEALTH DEPT

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Item 6 Filing 10

2/4/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02492 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02487

| | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|---|--|--|
| 1. DECEASED-NAME (Type or Print) Elwood | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 2 22 69 | | | 2b. HOUR 2:00 P.M. | | |
| 3. SEX Male | | | 4. RACE Colored | | | 5. DATE OF BIRTH 9/17/1929 | | | 6. AGE (In years last birthday) 38 3/4 | | |
| 7a. BIRTHPLACE (State or foreign country) Virginia | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Kent | | |
| 10. CITY OR TOWN OF DEATH R.F.D. Kennedyville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) At Home | | | 12a. USUAL OCCUPATION (Kind of work done during working life, even if retired.) Laborer | | | 12b. KIND OF BUSINESS OR INDUSTRY Various | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland | | | 13b. COUNTY Kent | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME Stanley | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME Virginia Daughtry | | | First Middle Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 2 27-30-727 | | | 17. INFORMANT BARKSDALE Terrace | | | Address 3014 Popular Baltimore, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 890 X Almost complete burning - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fire in trailer where he lived - DUE TO, OR AS A CONSEQUENCE OF (c) short | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH short | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. 2:00 P.M. 2:22 1969 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Trailer caught on fire - | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State near Kennedyville Kent Md | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Robert W. Farr | | | | M.D. Robert W. Farr M.D. | | | | 22b. DATE SIGNED 2-25-69 | | | |
| EXAMINER'S NAME (Type) | | | | ADDRESS Chestertown, Maryland | | | | 25a. REC'D BY REGISTRAR FEB 27 1969 | | | |
| 23a. BURIAL, CREMATION, or other disposal (Specify) Burial | | | | 23b. DATE 3/1/1969 | | | | 23c. NAME OF CEMETERY OR CREMATORY Janes Methodist Cem. Chestertown, Kent Md. | | | |
| 24. FUNERAL DIRECTOR J. Smith | | | | ADDRESS Chestertown, Maryland | | | | 25b. REGISTRAR'S SIGNATURE J. Smith | | | |

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RECEIVED
JUL 10 1964
U.S. AIR FORCE

DATE
TIME

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| 1. DECEASED-NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR | |
|---|--|--|---------|---|-------------------|--|---|--|------|
| EARL | | | KENNARD | JONES | Feb | Month | 2 | Day | 1969 |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Male | | White | | Feb. 6, 1901 | | 67 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Md. | | U.S. | | | | Kent | | Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Chestertown | | Kent & Queen Anne's Hosp. | | Merchant & Postmaster | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | Kent | | Still Pond | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Harry | | Eva | | No | | 218-20-6207 | | Hospital Records, Chestertown, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | 1-31-69 | | Cholodocholithiasis | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 9 hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 30, 1969, to Feb. 2, 1969, that (I) (we) last saw the deceased alive on Feb. 2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE A. C. Dick, M.D. | | 22c. DATE SIGNED 2-2-69 | | 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | |
| | | | | | | Chestertown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 2-5-69 | | STILL POND CEMETERY | | STILL POND KENT MD. | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| VICTOR N. KENNEDY | | DATE 6 1969 | | Charles Judge | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | |
|--|--|---------|--|--|--|--|---------------------------------|--|--|------------------------|-----------------------------|--|--|----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | |
| 82494 | | | | | | CERTIFICATE OF DEATH | | | 02489 | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | | | |
| Medford | | | Samuel | | | Jones Sr. | | | Feb Month 14 Day 1969 Year 2:25PM | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | |
| Male | | White | | Mar. 14, 1891 | | | 77 YRS. | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | |
| Maryland | | | U.S. | | | | | | Kent Co., Chestertown | | | Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Chestertown, Md. | | | | Kent & Queen Anne's Hospital | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | |
| Maryland | | | | Kent | | Chestertown | | | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| First Middle Last | | | | First Middle Last | | | | | | | | | | | |
| Purnell | | | | Jones | | | | Arbella | | | | Moore | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | Address | | | |
| No | | | | 220-22-0442 | | | | Hospital records | | | | Chestertown, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Coronary artery disease</i> | | | | | | | | | | | | 10 years | | | |
| 4124 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause lost. | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| <i>Pleural and arterial</i> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Jan 24, 1969, to Feb 14, 1969, that (I) (we) lost saw the deceased alive on Feb 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | 22c. DATE SIGNED | | | |
| <i>A. C. Dick</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | 2-14-69 | | | |
| 22d. PHYSICIAN'S NAME (Type) A. C. Dick, M.D. | | | | | | | | | | | | 22e. ADDRESS | | | |
| | | | | | | | | | | | | Chestertown, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| Burial | | | 2/16/1969 | | | Wesley Chapel Cem. | | | near Rock Hall, Md. | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| <i>J. Wells Wells</i> ADDRESS Chestertown, Md. | | | | | | | | | | | | DATE FEB 19 1969 | | <i>Charles Judge</i> | |

FOR STATE
HEALTH DEPT.

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02495

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02490

| | | | | | | | | | | | | |
|---|-------------------------|---|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME (Type or Print) Jennie | | | First Middle Last Karbaum | | | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Feb. 11, 1969 | | | 2b. HOUR 5:00 PM | | | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH Feb. 25, 1898 | 6. AGE (In years last birthday) 70 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD Month 2 Day 11 Year 1969 | | | 2d. HOUR 9:00 PM | | | |
| 7a. BIRTHPLACE (State or foreign country) Germany | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Kent | | | Md. | | | |
| 10. CITY OR TOWN OF DEATH Lynch | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY Kent | | 13c. CITY OR TOWN Lynch | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER --- | | | |
| 14. FATHER'S NAME Unknown | | | 15. MOTHER'S MAIDEN NAME Unknown | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT Frank Karbaum, | | | ADDRESS Box 443, Chestertown, Md. | | | 21620 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE Robert W. Farr | | | M.D. Robert W. Farr, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED 2-12-69 | | | |
| EXAMINER'S NAME (Type) | | | ADDRESS Kent | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE Feb. 15, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY Sudlersville Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Sudlersville, Q.A. Md. | | | | |
| 24. FUNERAL DIRECTOR Edward Fellows & Son, Millington, Md. 21651 | | | | | | 25a. RECEIVED BY REGISTRAR DATE FEB 14 1969 | | 25b. REGISTRAR'S SIGNATURE James J. Judge | | | | |

298 J. L. Davis

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doi:10.1017/S0022292410000516

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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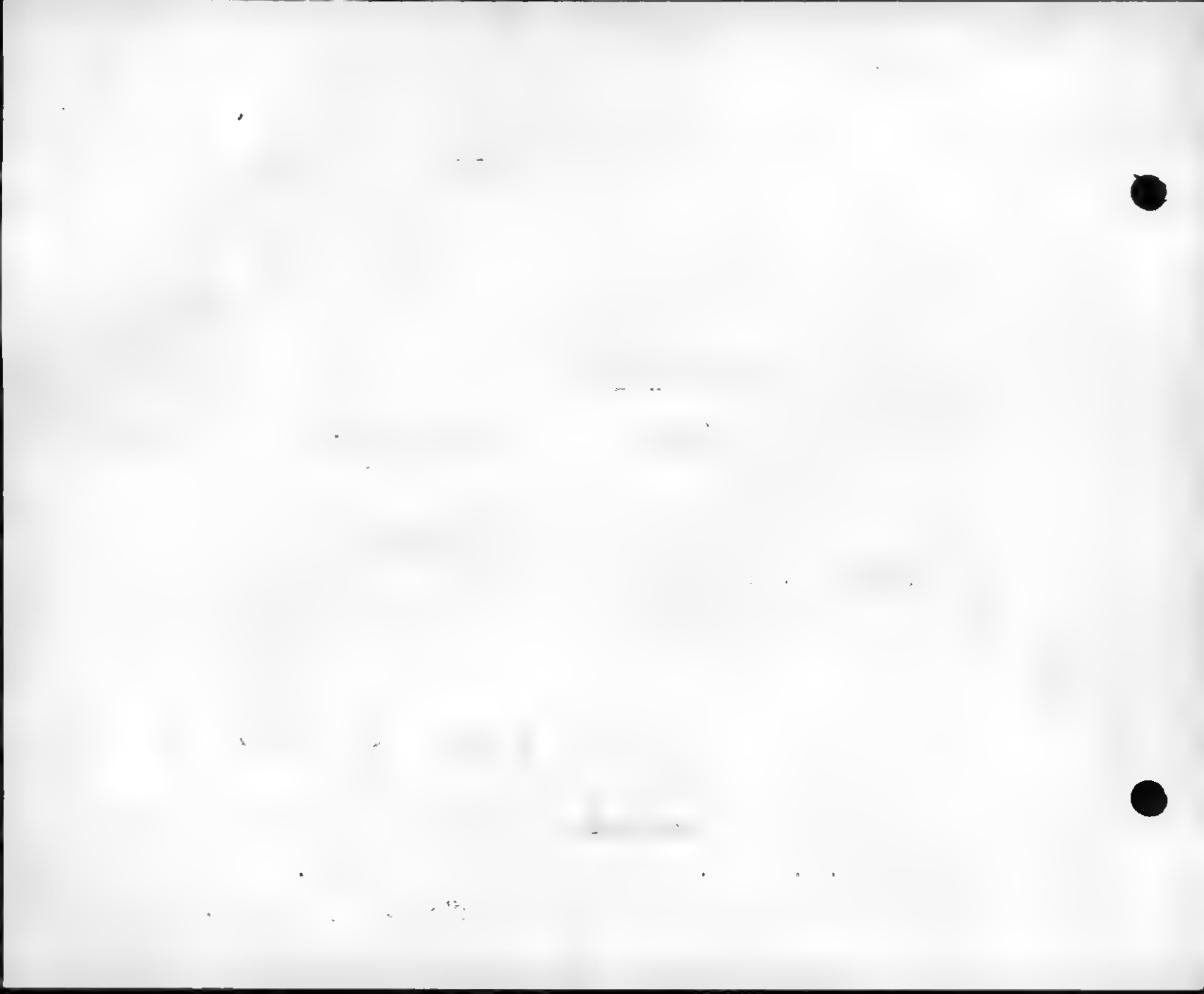
CERTIFICATE OF DEATH

02491

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|--|--|--|---|---|---|---|---|--|
| 1. DECEASED NAME (Type or print) Christian ? Kern | | | 2a. DATE OF DEATH Month Feb. Day 21 Year 1969 | | | 2b. HOUR P 8:07 M | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH 5-5-1898 | | 6. AGE (In years last birthday) 70 YRS | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Kent Md | | |
| 10. CITY OR TOWN OF DEATH Chestertown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) K & OA Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer | | |
| 12b. KIND OF BUSINESS OR INDUSTRY LABOR | | | 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland | | 13b. CITY OR TOWN Queen Anne Millington | | 13c. STREET AND NUMBER Ford's Landing | |
| 14. FATHER'S NAME First Middle Last John ? Kern | | | 15. MOTHER'S MAIDEN NAME First Middle Last Annie ? Welch | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) Yes | | | 16b. SOCIAL SECURITY NO 220-30-4921 | | 17. INFORMANT Hospital Records | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningeal meningitis 0360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pneumonia | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-20 , 19 69 , to 2-21 , 19 69 , that (I) (we) last saw the deceased alive on 2-21 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE A. C. Dick M.D. | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 2-21-69 | | |
| 22d. PHYSICIAN'S NAME (Type) A. C. Dick M.D. | | | | 22e. ADDRESS Chestertown, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 2/24/69 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem. | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Co. Maryland | | |
| 24. FUNERAL DIRECTOR St. Charles Judge | | | | ADDRESS Chestertown, Md. | | 25a. REC'D BY REGISTRAR FEB 25 1969 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE St. Charles Judge | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

McAlpin 12492

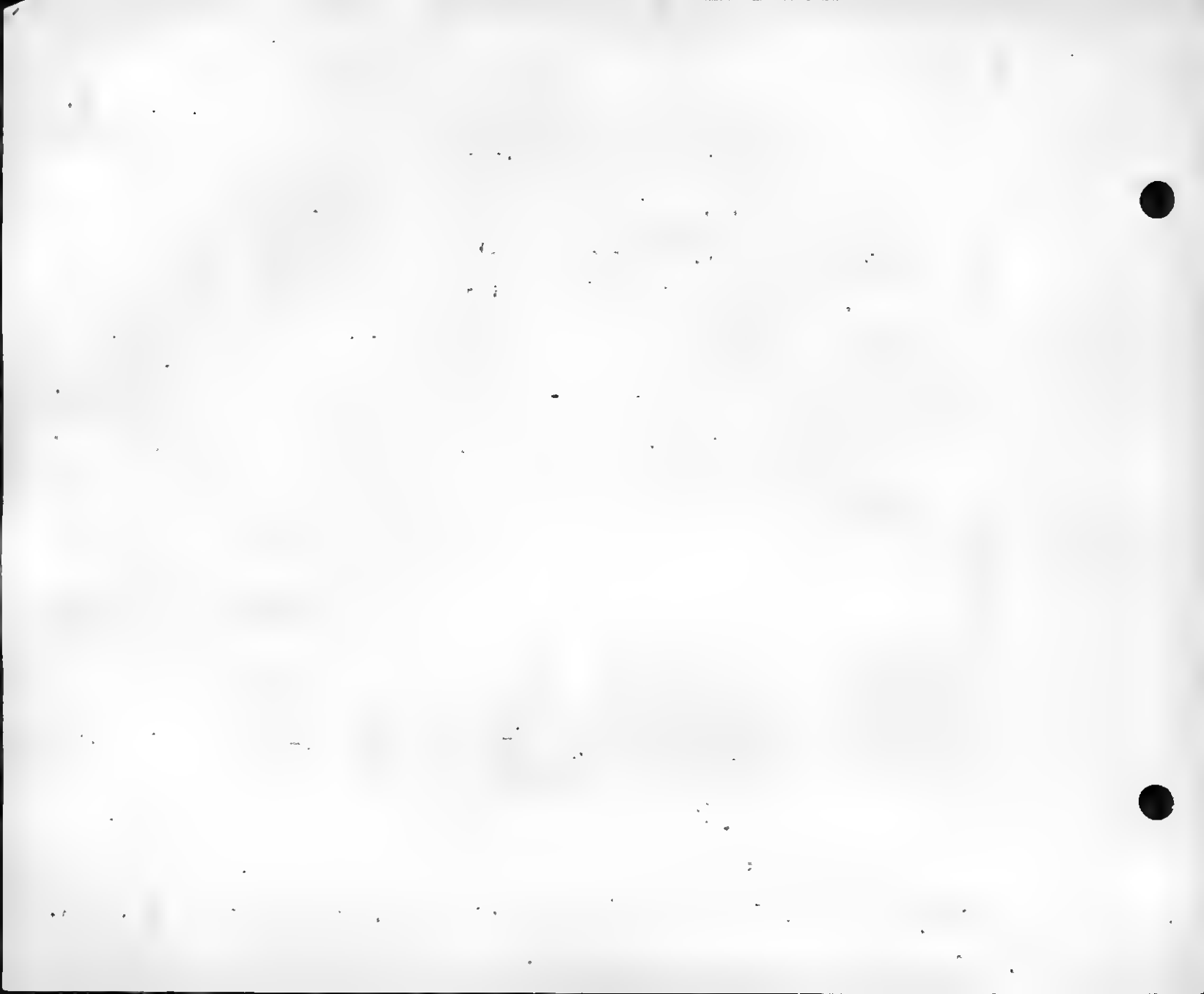
| | | | | | | | |
|--|-----------------|---|--|---|--|--|--|
| 1 DECEASED-NAME (Type or Print) William R. McAlpin | | First Middle Last | | 2a DATE KNOWN OF DEATH ESTIMATED FEB 16 1969 | | 2b HOUR 10:30 AM | |
| 3 SEX M | 4 RACE W | 5 DATE OF BIRTH 12-25-1904 | 6 AGE (In years last birthday) 64 YRS | 7 UNDER 1 YEAR MONTHS DAYS HOURS MIN | 2c DATE PRONOUNCED DEAD Month 2 Day 16 Year 1969 | | 2d HOUR 11:15 AM |
| 7a BIRTHPLACE (State or foreign country) New York | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Kent | |
| 10 CITY OR TOWN OF DEATH Chestertown, Rural | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Farm (at home) | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Banker | | 12b KIND OF BUSINESS OR INDUSTRY Retired | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | 13b COUNTY Kent | | 13c CITY OR TOWN Chestertown | | 13d INSIDE CITY, Y, N, T, S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e STREET AND NUMBER Rural | | 14. FATHER'S NAME First Middle Last David H. McAlpin | | 15 MOTHER'S MAIDEN NAME First Middle Last Emma Rockerfellow | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16b SOCIAL SECURITY NO. 055 14 1881 | | 17 INFORMANT ADDRESS Mrs. Kathleen M. McAlpin | | 17b CITY OR TOWN Chestertown Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bullet wound in head - DUE TO, OR AS A CONSEQUENCE OF self inflicted - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) self inflicted - DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH none |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> (CAUSE OF DEATH) about 10:30 AM 2/16/69 | | 21b TIME OF INJURY Month, Day, Year 2/16 1969 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) self inflicted - | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Farm owned by deceased | | 21f LOCATION Street or RFD No. City or Town Chestertown County Kent State Md | | | |
| 22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Robert W. Farr | | EXAMINER'S NAME (Type) ROBERT W. FARR | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 2-16-69 | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b DATE 2/17/69 | | 23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory | | 23d LOCATION (City or Town) (County) (State) Washington, D.C. | |
| 24 FUNERAL DIRECTOR J. Wilks Wells | | ADDRESS Chestertown, Md. | | 25a REC'D BY REGISTRAR DATE FEB 19 1969 | | 25b REGISTRAR'S SIGNATURE | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|---|--|--|---|---|---|--|---|---|-----------------------------------|--|------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last Hester Goldie Moore | | | | | | 2a. DATE OF DEATH Month Day Year 2 22 69 | | | 2b. HOUR M 1:10 | | | |
| 3 SEX Female | | 4. RACE Colored | | 5. DATE OF BIRTH 7-9-01 | | | 6 AGE (In years last birthday) 67 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Kent Md. | | | | | | |
| 10 CITY OR TOWN OF DEATH Chestertown | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kent & Queen Anne's | | | 12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired.) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) STATE Md. | | | 13b. COUNTY Kent | | 13c. CITY OR TOWN Chestertown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| 14 FATHER'S NAME First Middle Last George Thomas Henry | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Georgiana Rasin | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | | |
| 16b. SOCIAL SECURITY NO 144-20-4291 | | | | 17. INFORMANT Address Kent & Queen Anne's Hospital Md. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the Liver 1778 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH six mos. | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-10 , 19 69 , to 2-22 , 19 69 , that (I) (we) last saw the deceased alive on 2-22 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE DR Oteiza | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED Feb. 25, 69 | | | | |
| 22d. PHYSICIAN'S NAME (Type) Jorge Oteiza MD | | | | | | 22e. ADDRESS Chestertown, Maryland | | | | | | |
| 23a. BURIAL, CREMATION, REINTERMENT (Specify) Burial | | 23b. DATE 2/27/69 | | 23c. NAME OF CEMETERY OR CREMATORY Asbury Methodist Cem. | | | 23d. LOCATION (City or Town) (County) (State) Georgetown Kent Md. | | | | | |
| 24. FUNERAL DIRECTOR James Smith | | | | | | ADDRESS Chestertown, Md. | | 25a. REC'D BY REGISTRAR MAR 3 1969 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|---|--|------------------------------|---|--|------------------------------------|---|--|--|--|--|-----------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) | | | First Middle Last | | | 2a DATE OF DEATH | | | 2b. HOUR | | | |
| Francis Joseph Reskovitz | | | | | | Feb Month 28 Day 1969 Year | | | 12:55 PM | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Male | | White | | Oct. 14, 1924 | | | 44 YRS | | MONTHS DAYS | | HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | |
| Delaware | | United States | | | | Kent Co., Chestertown Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Chestertown | | | Kent & Queen Anne's Hosp | | | Highway Inspector | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER | | | |
| Maryland | | | Kent | | Chestertown | | | | | | | |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | |
| Ralph Reskovitz | | | Helen unk | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO | | 17. INFORMANT Address | | | | | | | |
| Yes | | | 1943-1945 | | Hospital Records - Chestertown, Md | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepatic failure + Coma</u> 2 <u>Heart attack</u> | | | | | | | | | | | | |
| 5719 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cirrhosis of liver</u> unknown | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| | | | | | | | | | | | | |
| 21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | |
| | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 4, 1969, to Feb 28, 1969, that (I) (we) last saw the deceased alive on Feb 28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | | |
| 22b. SIGNATURE <u>R. W. Farr</u> | | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c DATE SIGNED 2-28-69 | | | |
| 22d. PHYSICIAN'S NAME (Type) R. W. Farr, M.D. | | | | | | 22e. ADDRESS Chestertown, Md. | | | | | | |
| 23a B. URIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) (County) (State) | | | | |
| Burial | | | 3/3/69 | | St. John's Cemetery | | | Rock Hall, Md. | | | | |
| 24 FUNERAL DIRECTOR <u>J. Wilho Wells</u> | | | | | | 25a REC'D BY REGISTRAR <u>Mar 3 1969</u> | | | 25b REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | | | |
| ADDRESS Chestertown, Md. | | | | | | DATE | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|---|--|--|--|--|------------------------------------|--|---|--|--|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | | |
| Henry | | | NMN | | Siejack | | Feb | | Month 26 Day '69 Year | | | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | 7b. HOUR | | |
| Male | | | White | | April 11, 1909 | | | 59 YRS. | | 12:30 AM | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | |
| Maryland | | | United States | | | | | | Kent Co., Chestertown Md | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | 12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Chestertown | | | Kent & Queen Anne's Hosp | | | | | | Contractor | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Kent | | | Rock Hall | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | |
| Alexander | | | | | | | Siejack | | Rose | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT Address | | | | | | |
| No | | | 214 12 8059 | | | Hospital Records | | | | | | |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary arrest</u> | | | | | | | | | | 20 weeks | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Hypertension</u> | | | | | | | | | | 6 days? | | |
| (c) <u>Coronary artery disease</u> | | | | | | | | | | Years. | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| <u>Diabetes</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| | | | | | | | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 25</u> , 19 <u>69</u> , to <u>Feb. 26</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Feb. 26</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | | | | |
| <u>A. C. Dick</u> | | | 2/26/69 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | |
| A. C. Dick, M.D. | | | Chestertown, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | | 3/1/69 | | St. Paul's Cem. | | near Chestertown, Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | | | |
| <u>Wells</u> | | | Chestertown, Md. | | | MAR 3 1969 | | <u>Charles Judge</u> | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30M REV 1-55

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|--|--|--|--|--|--|---|---------------------------------|--|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | |
| Edna | | | Tolliver | | | Month 2 Day 9 Year 69 | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Female | | Colored | | 9/28/1914 | | | 54 YRS. | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | |
| Maryland | | U.S.A. | | | | Kent County Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Fountain | | | At Home | | | Factory | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| Maryland | | | Kent | | | Fountain | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | |
| Hiram | | | Wallace | | | Delia | | | Simmon | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | |
| | | | 220-16-9713 | | | William Tolliver | | | 136 Mon Tello Ave N.E. Washington, D.C. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 CORONARY OCCLUSION (acute) | | | | | | | | | | | 10 min | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY Insufficiency | | | | | | | | | | | 6 Months | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | | |
| | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9.19, 1968, to 2.6, 1969, that (I) (we) last saw the deceased alive on 2.6.69, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | 22e. ADDRESS | | 22c. DATE SIGNED | | |
| Geza Koralewski M.D. | | | | | | | | Millington, Maryland | | 2.8.69 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | | |
| Burial | | 2/11/69 | | Fountain Cemetery | | Fountain | | Kent | | Maryland | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Kenneth Waller | | | | Chestertown, Md. | | | | DATE FEB 13 1969 | | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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02502

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02497

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED-NAME (Type or print) First Middle Last Nora Mae Walraven | | | 2a. DATE OF DEATH Feb., 21, 1969 Month Day Year 10-5-1889 | | 2b. HOUR 9:00 PM |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH 10-5-1889 | | 6. AGE (In years last birthday) 79 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) Q. A. Co. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Kent Md. | | |
| 10. CITY OR TOWN OF DEATH Chestertown | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) K. & QA Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Nursing Home Worker | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Queen Anne | 13c. CITY OR TOWN Sudlersville | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER |
| 14. FATHER'S NAME First Middle Last Daniel Edward ? Cannon | | 15. MOTHER'S MAIDEN NAME First Middle Last Jennie V. Buckle | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no | | 16b. SOCIAL SECURITY NO. 222-12-0455 | 17. INFORMANT Hospital Records | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Collapse 4124 DUE TO, OR AS A CONSEQUENCE OF (b) Heart A. S. C. V. Disease DUE TO, OR AS A CONSEQUENCE OF (c) Post-operative Atelectasis & Pneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hr 2 days | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION 2-17-69 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholelithiasis | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-14, 1969, to 2-21, 1969, that (I) (we) last saw the deceased alive on 2-21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Arthur T. Keefe M.D.</i> | | | | 22c. DATE SIGNED 2-21-69 | |
| 22d. PHYSICIAN'S NAME (Type) Arthur T. Keefe M.D. | | | | 22e. ADDRESS Chestertown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Feb. 24, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY Sudlersville Cemetery | |
| 23d. LOCATION (City or Town) Sudlersville, Q.A. | | (County) Kent | | (State) Md. | |
| 24. FUNERAL DIRECTOR Edward Fellows & Son, Millington, Md. 21651 | | 25a. REC'D BY REGISTRAR FEB 26 1969 | | 25b. REGISTRAR'S SIGNATURE <i>John H. Judge</i> | |

